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OCCUPATIONAL THERAPISTS' PERCEIVED EXPERIENCES IMPLEMENTING RESPONSE TO INTERVENTION (RTI) IN EARLY EDUCATION

By

McKenzie Katzman

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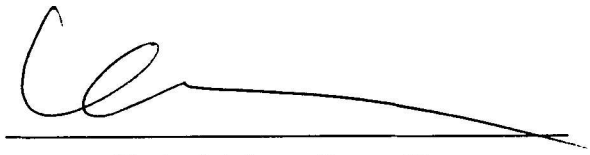

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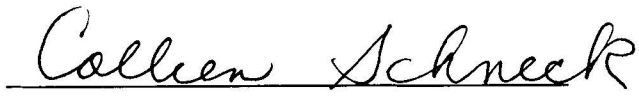

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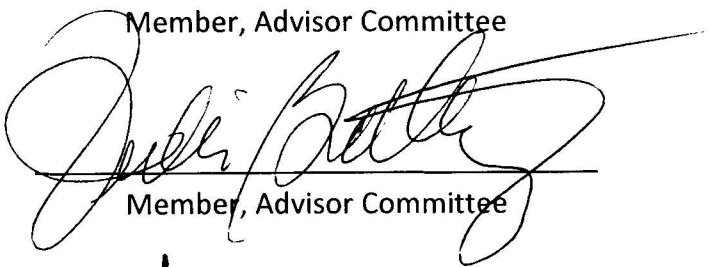

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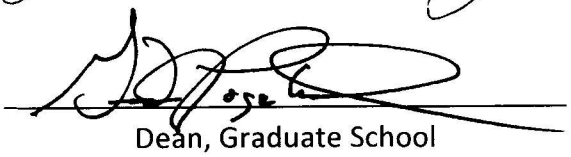

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2014

Submitted to the Faculty of the Graduate School of
Eastern Kentucky University
in partial fulfillment of the requirements
for the degree of
MASTER OF SCIENCE IN OCCUPATIONAL THERAPY
August 2015

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DEDICATION

This thesis is dedicated to my extremely supportive Mom, Julia Katzman, Dad, Thomas Katzman, and Grandma, Martha Katzman for selflessly putting my needs ahead of their own throughout my 7-year college experience.

ACKNOWLEDGMENTS

I would like to thank my thesis advisor, Dr. MaryEllen Thompson PhD, OTR/L for her loving support, impeccable guidance and flexibility throughout both the development of my thesis and personal endeavors. I would also like to thank my thesis committee members, Dr. Colleen Schneck ScD, OTR/L, FAOTA, and Dr. Julie Baltisberger PhD, OTR/L for their revisions and assistance contributing to the completion of my thesis. I would like to express my gratitude towards my family, friends, and classmates in Kentucky and Tennessee for constantly believing and encouraging me in overcoming every milestone experienced while completing my Master's thesis.

ABSTRACT

The purpose of this qualitative research study is to gain a better perspective of occupational therapists' perceived experiences when implementing Response to Intervention (RtI) in early education. RtI is an emerging practice area in Occupational Therapy. Three Kentucky occupational therapists, working in the school system in different counties, were recruited through email and snowballing. Semi-structured interviews were conducted in person with participants. Information gathered was transcribed verbatim and transcripts were examined for purposes of coding. Coding was compared across cases and examined for themes. Despite commonalities, three distinct experiences of RtI emerged. Implications for occupational therapists working in the school system will be discussed.

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Chapter 1

Introduction

Response to Intervention (RtI) is a relatively new form of educational service that may utilize the services of occupational therapists. National laws related to this emerging practice area are written in a broad manner, so implementation and interpretation of these laws vary greatly by state, district, and school (Individuals with Disabilities Education Improvement Act H.R.1350, 2004). The extent to which RtI is ultimately implemented is also affected by the individual work challenges and resources of the occupational therapists charged with assisting in RtI implementation. Because RtI is an emerging practice area in the field of occupational therapy, it is important to understand occupational therapists' perceived experiences of implementing RtI and how these experiences are affected by funding options available, by acceptance of RtI as a valuable part of education, and by the laws and regulations governing both their practice and the rights of the students. The purpose of this study is to better understand the perceived experiences of occupational therapists implementing RtI in early education school systems.

Literature Review

Some knowledge of early laws enacted to support children with learning disabilities helps to clarify the laws affecting Response to Intervention (RtI) implementation. The following laws and regulations are provided in chronological order to signify the amount of change and growth witnessed throughout history.

In 1973, the Children With Specific Learning Disabilities Act was introduced as a bill to House Representatives as it authorizes the Commissioner of Education to make grants to carry out a program of:

1) Research relating to the education of children with specific learning disabilities
2) Training of personnel to teach such children
3) Establishing model centers for the improvement of education of these children, these centers to provide testing and evaluation to identify these children, develop programs to meet their special needs, and assist other organizations in making such programs available to other children (Children With Specific Learning Disabilities Act H.R. 1769, 1973).

Little did society know, this bill would lay the foundation for a successful approach towards education and a child's academic achievement.

In 1975, advocates convinced Congress to pass the Children With Specific Learning Disabilities Act which mandated support services for students with learning disabilities (Bailey, Bray, Eversole, Lovell, Rogers, Sharpe, Sullivan, & Weber, 2014). The Education for All Handicapped Children Act was passed in 1975 to ensure that "all handicapped children have available to them special education and related services designed to meet their unique needs" (Education for All Handicapped Children H.R. 7217, 1975). The Education for All Handicapped Children Act, also referred to as the constitutional protection for children with disabilities and their families, was written to incorporate six major components that had an everlasting impact on education including: 1) a Free, Appropriate, Public Education (FAPE) for all students; 2) a Least Restrictive

Environment (LRE); 3) an Individualized Education Program (IEP); 4) procedural due process; 5) nondiscriminatory assessment; and 6) parental participation (Project IDEAL, 2013). The FAPE component provides all students, regardless of the severity of the disability, an "education appropriate to their unique needs at no cost to the parent(s)/guardian(s)" and also includes the use of related services determined to be educationally relevant and beneficial to the student (Project IDEAL, 2013). The purpose of the LRE component is to provide students with disabilities the opportunity to receive the same education to the maximum extent possible as students without disabilities (Project IDEAL, 2013). An IEP is an individually tailored statement describing the educational route a child will travel with regards to special education and related services needed by the student. Within the IEP, six critical points are to be addressed including:

1) The present level of academic functioning

2) Annual goals and accompanying instructional objectives

3) Educational services to be provided

4) The degree to which the pupil will be able to participate in general education programs

5) Plans for initiating services and the length of service delivery and

6) An annual evaluation procedure specifying objective criteria to determine if instructional objectives are being met (Project IDEAL, 2013).

Procedural due process enables parent(s)/guardian(s) to have the right to confidentiality of records, the ability to obtain an independent evaluation, and to receive written notification of changes made to the student's educational track (Project IDEAL, 2013). Nondiscriminatory assessment implementation requires that students be evaluated by a

multidisciplinary team in all areas of suspected disability and that this assessment not be biased on race, culture, and linguistics. Meaningful parental involvement helps to ensure educational success of students.

In 1990, the Education for All Handicapped Children Act was replaced by the Individuals with Disabilities Education Act (IDEA) deleting the term "handicap" and replacing it with the term "disabilities" allowing for more attention to be on the individual rather than fixated on the labeled condition (Jackson, 2007). The IDEA focuses on the education of students with disabilities and now provides students with an Individual Transition Plan (ITP) as part of their IEP. The American Psychological Association (APA) defines the Individuals with Disabilities Education Act (IDEA-04) of 2004, a refined plan, as a method to prepare students with learning disabilities for further education, employment, and independent living (American Psychological Association, 2014). Driscoll and Nagel (2010) summarized the IDEA as a push for students with disabilities to be educated alongside students without disabilities and that removal of students with disabilities from the regular education environment be deemed necessary only when supplementary aids and services cannot otherwise be achieved satisfactorily (p.1). Education provided to students within the LRE fosters optimal performance.

The IDEA has four distinct sections: A, B, C, and D. Section A lays the foundation for the rest of the act by defining terms. Section B focuses on service implementation for children and students aged 3-21 years of age. The IDEA provides financial support for state and local school districts for students aged 3-21 years of age as long as they comply with six main points:

1) Achieved FAPE

2) A school professional's belief that a particular student may have a disability impacting the student's ability to learn

3) Creation of IEP

4) Achieved LRE

5) Input received from both student and parent(s)/guardian(s) and

6) Confirmation that due process has taken place (American Psychological Association, 2014).

Section C pertains to reaching out to the population of infants and toddlers with disabilities within the home setting. Families are entitled to 1) multidisciplinary identification and intervention implementation; 2) an Individualized Family Service Plan (IFSP) encompassing priorities, resources, and concerns pertaining to their child's individual needs; 3) and timely resolution to all conflicts (American Psychological Association, 2014). Section D describes national initiatives to improve the education of children with disabilities such as grants, support programs, projects, and activities. With the revision of IDEA in 1997, more access to the general education curriculum for students with disabilities was demanded of states including alternative assessments to meet the student's unique needs. Regular education teachers are included in the IEP process, bridging the gap between environmental barriers for students with learning disabilities and a functional LRE. Assistive technology needs were to now be considered by the IEP team to assist the student's ability to learn.

As stated by the National Center for Learning Disabilities, the No Child Left Behind Act (NCLB) of 2001 is the current version of the Elementary and Secondary Education Act (ESEA) which became law in 1965 (No Child Left Behind Act of 2001

H.R.1, 2001). NCLB is important in that it ensures that students with learning disabilities reach high levels of academic standards just like their peers who are not living with a disability. It is based on four core principles (National Center for Learning Disabilities, 2014):

1) Stronger accountability for results
2) Increased flexibility and local control (funding)
3) Expanded options for parents (availability of report cards and possible transfers to more accredited schools as applicable)
4) An emphasis on teaching qualifications and methods whereby all teachers must hold a bachelor's degree and have passed a state test of subject knowledge.

Schools are held accountable for what the students learn, how they learn it, and whether the methods chosen to teach material are successful. NCLB's accountability requirements for schools promote the inclusion of students with disabilities in the assessment experience as a result of receiving more general education exposure. NCLB also explains the need for accommodations uniquely designed for each student to help students demonstrate their knowledge and skills rather than the effects of their disability. According to the National Center for Learning Disabilities (2014), by the end of the 2013-2014 school year, schools were required to achieve proficient levels in math and reading, and this includes students with learning disabilities (p.2). Not to say, students with disabilities cannot perform at the same level as those students without disabilities, but that they may require particular modifications to their learning environment to ensure their success.

IDEA's most recent revision took place in 2004 becoming State Law in all States on July 01, 2005. With the revision, came its alignment with NCLB of 2001 to ensure that a quality program is provided for all children with special needs (Individuals with Disabilities Education Improvement Act of 2004 H.R.1350, 2004). The newest provision in this revision is the ability for schools to use a scientific, research-based intervention such as RtI as part of the evaluation process instead of using a discrepancy formula (IQ score) to identify students with learning disabilities (Project IDEAL, 2014). Although RtI is not mandated under IDEA or NCLB, the reauthorization of IDEA 2004 uses language parallel to that of RtI. With IDEA, more children will have an array of services readily available to them including occupational therapy, often critical to the child's development and success in a LRE which will be further discussed later in this chapter. We will discover that the mind and body are two separate entities. RtI is used not only in middle and high schools, but also in the elementary setting to aid children in reading, mathematics, and behavior (National Center on Response to Intervention, 2012).

Funding/Reimbursement

Related services such as occupational therapy are seen as expensive health expenditures as opposed to an educationally relevant service within the school system. Occupational therapy is seen as part of the problem rather than part of the solution to meeting the needs of children with disabilities mainly because of funding difficulties (Jackson, 2007). Federal funds are provided in part because of the No Child Left Behind Act of 2001 in conjunction with IDEA-04, however, funding is sparse (Jackson, 2007).

Medicaid is a federal-state matching entitlement program designed to help provide and pay for health and medical services for low-income people. It is widely used

in the school system although there is controversy over what is considered billable for occupational therapy services (Jackson, 2007). Medicaid in the school system is designed specifically to allow schools districts to act as health care providers and be reimbursed for services (Jackson, 2007). Medicaid provides both a medical and educational lens to care. Each domain requires the use of goal setting for clients. The ways in which goals are constructed have an impact on the certainty of reimbursement for services. Each state is demanded to provide services to certain mandatory populations but have flexibility in determining coverage for optional population groups (Medicaid.gov, 2014).

ECE (Early Child Education) Program is devoted to meeting the needs of children who learn differently from their peers. This type of reimbursement system provides a small percentage of federal funding for occupational therapy services directly related to special education.

SEEK funding was started in 1990 in order to assist in equalizing funding for schoolchildren regardless of economic circumstances or place of birth and create a mechanism for distributing state support to local school districts (Kentucky Department of Education, n.d.). The costs associated with educating children with special needs and different disabilities is based on the number of students, student-teacher ratio for each disability or service, and a resulting per pupil cost (Kentucky Department of Education, n.d.).

Section 504 of the Rehabilitation Act of 1973 and Title II of the American with Disabilities Act (ADA) of 1990 constitute two civil rights statutes that prohibit discrimination on the basis of disability by programs receiving federal funds (section

504) and by services and activities of state and local governments (Reeder et al, 2011). Students who are not eligible for special education but have a disability that interferes with one or more aspects of life can receive occupational therapy services under this type of funding.

National Implementation of Response to Intervention in 2008 And 2009

Some states require implementation of RtI while others do not even though RtI has been shown to improve students' overall success in school. In 2008, research was conducted to better understand the national perspective and level of emphasis on RtI implementation from special education state department directors in all 50 states along with the District of Columbia (Hoover, Baca, Wexler-Love, & Saenz, 2008). This study used an 18-item survey to gather information on the following topics (Hoover et al, 2008, pp.3-4):

1) Current RtI emphasis in the states

2) Percentage of districts within the states using RtI

3) The purpose for using RtI

4) Current/Existing developments for statewide training of educators to use RtI

5) Topics most/least emphasized in the statewide trainings

6) RtI decision-making models most/least used by the state's school districts as well as the use of RtI specialists to assist with implementation.

Although states were not specified in this study, a remarkable 86% of respondents completed the research study. Results indicated that of the 44 states that had responded, 100% reported that they were either currently implementing or considering implementation of RtI. The percentage of districts within the states currently

implementing RtI surprisingly resulted in 7 states reporting that fewer than 10% of their districts are currently using RtI; 11 states indicated that 10-25% of their districts are using RtI; 4 states reported that 26-50% of their districts are using RtI; 1 state reported that 75% of their districts are using RtI; and 11 other states either did not answer or reported that statistics are currently unknown (Hoover et al, 2008). Another interesting finding from this study included state training efforts. Forty-one states concluded that state-level training was being conducted while 3 states reported not providing statewide training initiatives. The provided data clearly demonstrate the inconsistency of state and local decision-making with regards to RtI and the lack of uniformity in states' implementation of RtI.

Other evidence includes a project forum conducted a year later looking at specific states' implementation of RtI including Colorado, Florida, Iowa, Kansas, Pennsylvania, and Rhode Island (Burdette & Etemad, 2009). The National Association of State Directors of Special Education (NASDSE), IDEA Partnership, and the National Center on Response to Intervention (NCRTI) were used collaboratively to choose states based on their RtI framework and the variability of implementation in each. Colorado, Florida, Iowa, Kansas, Pennsylvania, and Rhode Island all demonstrated use of RtI when determining learning disabilities in K-12th grade students as a special education regulation initiative rather than using a discrepancy model.

The variability lies within the challenges faced by each state and these challenges have a strong impact on the effectiveness on the outcomes of services. Florida identified funding that would be used in conjunction with IDEA funds as its greatest challenge. Kansas noted that it needed to increase efforts to ensure the fidelity of planning and

implementing RtI. Finally, Pennsylvania noted concern with achieving consistency of RtI implementation by the Local Education Agencies (LEA's) across districts. Other concerns and barriers to successful implementation include inadequate or complicated funding options, insufficient training, lack of resources, and a lack of knowledge in proper execution of RtI components (Burdette & Etemad, 2009).

Response to Intervention (RtI)

RtI gained recognition in 2001, was later (in 2002) endorsed by the President's Commission on Excellence in Special Education, and in 2003 was endorsed by other professional organizations (Christ, Burns, & Ysseldyke, 2005). RtI methods continue to evolve as the approach matures. The purpose of RtI is to make sure that, "…every child in the school receives instruction that leads to success" and this approach is endorsed by many nationally known organizations including the United States Office of Special Education, IDEA Partnership, and National Association of State Directors of Special Education (The National Center on Response to Intervention, 2012, p.4; Danielson, 2007). As a high-quality service and tool used to identify students with Specific Learning Disabilities (SLD), provided that rigorous scientific-based research is embedded in the general education curriculum, RtI is shown to work well with students requiring extra assistance in the classroom (National Center on Response to Intervention, 2012, p. 20). RtI is seen as a safety net in that it supplies students with appropriate supports before the student has a chance to fail (The IRIS Center for Training Enhancements [B], 2006). It is important in RtI to first examine the curriculum and how it is being taught in the classroom as opposed to first assuming that the student has a learning difficulty so that lack of instruction can be ruled out. RtI has three Tier levels, each with the potential

to increase in intensity, frequency, and duration of services depending on the specific needs of the student.

Tier 1 encompasses a whole-classroom approach to intervention in which every student benefits from the same instruction. This level is exceptionally beneficial according to the Division for Early Childhood of the Council for Exceptional Children (DEC), National Association for the Education of Young Children (NAEYC), and National Head Start Association (NHSA) because not only is it using the prescribed instruction to assist students already identified as having a learning disability but also to assist students who were not known to experience difficulties but who soon identify their own struggles in learning (Pretti-Frontczak, Carta, Dropkin, Fox, Grisham-Brown, Edwards, & Sandall, 2013; Shaprio, n.d.; The IRIS Center for Training Enhancements [A], 2006) . Tier 1 is designed with the expectation that approximately 80% of students are successful in the general education curriculum (Danielson, 2007; Pretti-Frontczak et al, 2013; Shapiro, n.d.; AOTA, 2008). Tier 1 is the foundation for the other Tiers and supports the belief that if intensive support and instruction are provided, it is less likely that children will need the other Tiers (Pretti-Frontczak et al, 2013). However, it is expected that at least 15% of students may be at risk or may need more targeted interventions (Danielson, 2007; Pretti-Frontczak et al, 2013; Shapiro, n.d.; AOTA, 2008). Students demonstrating difficulty in mastering abilities in Tier 1 will be given supplemental teaching and support that are provided in Tier 2. If the Tier 2 escalation is deemed unsuccessful, the student will be moved to Tier 3 and assisted with highly individualized teaching practices and possible referral for special education and related services. Approximately 5% of students who do not respond to interventions in Tiers 1

and 2 will end up in Tier 3 (Danielson, 2007; Pretti-Frontczak et al, 2013; Shapiro, n.d.; AOTA, 2008).

Throughout each Tier, progress monitoring of a student's growth is used to measure the success of the level of instruction provided. From those results, adjustments may be made to increase or decrease the amount of support provided. The goal of the Tiered approach is to allow increased support as needed for student success which can be adjusted over time to facilitate increased independence. A key component to successfully implementing RtI is the constant communication and collaboration between teachers and other school professionals. Meetings consist of a discussion of problem-solving skills and of data comparisons based on time and intensity of intervention to aid in decision-making processes. A great deal of reflection is dedicated to the assessment of the effectiveness of the Tiered intervention on an individual student's success. In order to fully understand the effects of service on the student, it is important to get the student's perceived experiences pertaining to the components of service (intensity, frequency, and duration) along with other barriers to performance the student may encounter in order to best select probable solutions to performance.

Discussions surrounding the implementation of RtI often expose controversy pertaining to the consistent execution of its principles or to its fidelity, despite the supportive literature (Castillo & Batsche, 2012). The overall effectiveness of RtI will be determined by how well schools abide by RtI implementation across students, grades, schools, and districts. There is currently a lack of consistent implementation of RtI in the United States. There is also controversy as to whether RtI should be viewed in some contexts as more of an eligibility determination factor than a tool to improve student

outcomes (Castillo & Batsche, 2012). Ongoing professional development and training remains a challenge as the results of outcomes are based on the integrity of services implemented. If Tiers are not implemented the way they were originally designed, then desired outcomes may be skewed. Because personnel may change throughout the year and subsequent years, it is vital that new educators entering a setting that uses RtI be supplied with adequate tools such as instruction in mentoring or modeling and that they stay current with research findings.

Response to Intervention – Kentucky

Kentucky envisions a future in which, "…all students reach proficiency and graduate from high school ready for college and careers" (Bailey et al, 2014). The Kentucky Administrative Regulations (KAR) for special education programs outlines two possible identifiers for Specific Learning Disabilities (SLD) determination including a severe discrepancy method and the RtI method (Determination of Eligibility 707 KAR 1:310, 2007. Belcher, Overly, Dossett, Nemes, Tilley, and Wuchner (April, 2012), members of the General Assembly of the Commonwealth of Kentucky, define a Specific Learning Disability (SLD) as:

> …a disorder in one (1) or more of the psychological processes primarily involved in understanding or using spoken or written language which selectively and significantly interferes with the acquisition, integration, or application of listening, speaking, reading, writing, reasoning, or mathematical abilities (p.6).

Belcher et al (April, 2012), assisted in amending a new section under chapter 158 under HB69 of Kentucky Legislature to "…require the Department of Education [district-wide] to make available technical assistance, training, and a web-based resource to assist all

local school districts in the implementation of the system (RtI) and instructional tools based on scientifically based research..." as a means to assist students experiencing difficulties in math, reading, writing, or behavior (p.2). Technical assistance and training incorporate the use of specific screening processes to identify students' strengths and weaknesses and the use of multisensory instructional strategies to promote the effectiveness of scientifically based research and the progress monitoring of students' performance (Belcher et al, April, 2012). This particular amendment also emphasizes the importance of the Department of Education's encouragement of districts to utilize both federal and state funds as appropriate to most effectively implement district-wide RtI.

Caudix and Hinkleman (2011) provide the findings of a nation-wide survey conducted by GlobalScholar, the National Association of the State Directors of Special Education (NASDSE), Council of Administrators of Special Education (CASE), and the American Association of School Administrators (AASA) that gauged to what extent RtI was being adopted and implemented (p.1). The survey revealed 94% of respondents nationwide were within a particular stage of RtI implementation. However, it is interesting and important to note that schools within smaller districts were less likely to implement RtI. Elementary schools were found to lead the way in RtI implementation helping to ensure that methods to success are discovered as early as possible. In a report issued after implementation of the amendment, Nickerson (June, 2013), a government and policy reporter, stated that because of the numerous organizational challenges reported in implementation of RtI from varying school districts, the data on the number of school districts implementing RtI and on RtI effectiveness in improving student performance in Kentucky schools have been delayed (p.1). Surveys used to assess RtI's

effect on education strongly indicate that the federal government should devote more resources to schools for RtI related activities.

In Kentucky, RtI is prescribed for a child who "…fails to achieve a rate of learning to make sufficient progress to meet grade-level standards in one or more of the eight SLD subcategory areas when assessed based on the child's response to scientific, research-based intervention" (Bailey et al, 2012). SLD subcategories include visual, hearing, motor, intellectual, and emotional-behavioral disabilities, cultural factors, environmental or economic disadvantage, or limited English proficiency (Bailey et al, 2012). However, RtI implementation is not to cause the delay of initial evaluations for students suspected of having a disability. In other words, a student with a disability does not have to wait until Tier 3 in order to begin the evaluation process for an IEP and special education services. Kentucky recognizes that the multi-Tiered approach will be implemented differently across schools; however, the guiding principles and core components of the Tiers should be evident regardless of the school setting.

The increasing diversity in RtI implementation has caused concern for R. Larry Taylor, director of the Division of Learning Services in the Office of Next Generation Learners. In a letter to Kentucky State Governor, Steve Beshear, in 2010, R. Larry Taylor expressed his concern with various districts' ability to follow IDEA procedures in federal and state law (Taylor, 2010). Part of the failure may be due to the lack of understanding in how to teach students with different learning styles and this lack of understanding results in some students lagging behind their peers. The fact is that some students who simply employ a different learning style may be unnecessarily placed in special education. RtI encourages the matching of diverse learners with the appropriate

differentiated instruction thereby meeting students' needs in general education without the need of special education. In other words, RtI allows us to adjust the teaching method for the child instead of trying to change the child to fit the teaching method.

Response to Intervention (RtI) – Occupational Therapy

RtI requires consistency in implementation strategies in order to promote successful learning, effective communication of student performance with team members and parent(s)/guardian(s), an understanding of diverse learning styles of students, and the inclusion of advice from paraprofessionals if desired. Occupational therapists fall into the category of paraprofessional because of their competencies in the field and knowledge of other licensed staff. According to the American Occupational Therapy Association [AOTA], occupational therapists are highly qualified, licensed professionals who work with an array of populations and medical conditions (AOTA, 2008). In school systems, occupational therapists promote function and engagement of all children in school participation. Occupational therapists are required to have background knowledge of advanced anatomy, neurophysiology, sensory processing, development, and mental health fields. Occupational therapists are specialists in the determination of appropriate instructional strategies in the school setting based on their scope of practice and ability to break down complex tasks. The 2004 revision of IDEA allows occupational therapists to play more of a direct role in Early Intervening Services (EIS), throughout each Tier, for students in general education who do not receive special education services in order to provide assistance with students who may require a simple tweaking to improve their performance. Occupational therapists play a large role with the special education population in that they provide a more structured and functional environment with

possibly the use of AT (assistive technology). AT can be described as special tools supplying support to a child's ability to write, stay seated, and keep attention on assigned tasks.

Occupational therapy, as a related service in the school setting under IDEA part B for children 3-21 years of age and in conjunction with NCLB of 2001, supports children and youth by promoting participation in home, school, and community life (AOTA, 2008). As agents of change, occupational therapists support behavioral, academic, and functional performance along with social participation of students at school. Occupational therapists possess the skills necessary to create an optimal environment through activity analyses (break down of body requirements per step in tasks) for student success, environmental modifications (including universal design where everyone benefits from the same service), and integration of assistive technology (devices used to increase independence). Within the school-based setting, occupational therapists are qualified to provide direct and non-direct services including implementation of RtI.

In Tier 1 of RtI, occupational therapists may provide education and training to teachers and assist with universal screenings for instructional purposes. Universal Design for Learning (UDL) is used to support differentiated instruction of students with and without disabilities that constitute "…equal access, flexibility, simplicity, perceptibility, and efficiency to both the educational environment and to the process of teaching and learning" (Cahill, Clark, Olson, & Polichino, 2014; Post, 2010). Whole-classroom intervention is appropriate at this level including bully prevention programs, handwriting workshops, and various body awareness activities such as whole-body movements in space while manipulating various sized objects. Other services include sensory

processing workshops involving tactile (fingers/hands), oral (mouth), vision, auditory, olfactory (smell), vestibular (conception on body's position in space), and proprioception (tendons, joints, and muscles of the body) for educators' professional development; assistance for teachers in the modification of the classroom environment to incorporate more ergonomically sound components for the identified needs of students; and the support of new teachers in establishment of classroom routines (AOTA, 2008; AOTA, 2007).

In Tier 2 of RtI, occupational therapists may review data collected by the teachers in general education, provide suggestions to general education staff, and assist the general education staff by providing modeling or mentoring based on episodic problem solving. This level also warrants advice from the occupational therapist who may create intensive instruction supplements for some students. These supplements are created with a focus on a student's individual needs, are communicated to the general education teacher, and may include intervention packets such as worksheet activities that the teacher implements emphasizing focus on the child's deficit areas. The occupational therapist may also collaborate with the general education teacher to develop stations in the classroom utilizing adaptive tools and strategies to support participation of a small group of students requiring intervention (AOTA, 2008; AOTA, 2007). Suggestions for adaptive playground equipment and activities to support social play and participation can also be provided by the occupational therapist to ensure that required movement for appropriate developmental growth is being implemented within the currently supplied playground equipment.

In Tier 3 of RtI, occupational therapists may continue to review data produced by the general education teacher and assist the team in determining if a particular student is suspected of having a disability impeding their ability to excel in the classroom. Occupational therapists begin their part of the evaluation according to state practice requirements, and this includes administering assessments to identify barriers to learning for students experiencing difficulty. Examples of Tier 3 implementation by an occupational therapist are the recommendation of sensory strategies, as mentioned before, for a specific child and the recommendation of organizational strategies for a student experiencing difficulty, for example, with completing and submitting homework on time (AOTA, 2008; AOTA, 2007). Completion of in-depth assessments appropriate to the child's chronological age and deficit area allow the occupational therapist to provide adequate care.

Occupational therapists are not only able to collect data on student progress throughout the Tiers but can offer the team information regarding determinants on the efficacy of intervention towards student outcomes. Occupational therapists devise adaptations as applicable to the needs of individual students and may offer supportive advice to the team including recommendations for students to receive more intensive or less intensive intervention dependent upon the child's response. Occupational therapists facilitate student access to curriculum and extracurricular activities as well as obtain a critical role in training parents, caregivers, and other support staff on the diverse learning needs of students and how to best accommodate those skills and abilities (AOTA, 2010).

Requirements for delivering RtI services vary between states and not all states have adopted RtI (AOTA, 2008). Occupational therapists must carefully review their

state's practice act to identify information pertaining to proper language/terminology, proper RtI implementation procedures, proper billing procedures, proper progress monitoring, and proper structure of Tiered intervention.

Caseload vs. Workload

The school system serves as the foundation for many services to students in need. Each professional abides by his/her specific role as indicated by his/her practice. In relation to RtI, occupational therapists in particular must perform a juggling act involving both a caseload and a workload. A caseload refers only to those students seen by the occupational therapist that are in special education and have an IEP (Jackson, Polichino, & Potter, 2006). According to the same authors, a workload is defined as all of the work activities performed that benefit students with and without disabilities. This workload is increased by the expectation that occupational therapists are to be available to students as needed. A main difference between a caseload and a workload is that the workload includes management of the complexity of services addressed by the IDEA of 2004 principles in order to support access to and progress in general education curriculum (Jackson et al, 2006). RtI is that workload component of school-based service that deserves more attention.

Occupational Therapists Perspectives and Contributions to Response to Intervention (RtI)

Occupational therapists' perceived experiences in Response to Intervention implementation have received little attention. Clark, Ivey, and Olson (2013) offer personal reflections from their experiences in varying school districts as occupational therapists implementing RtI. These expert opinions offer insight into their experiences

implementing RtI in three different states (Virginia, New York, and Iowa) and conclude that occupational therapy, no matter the state's level of RtI adoption should advocate for their contributions to students educational successes (Clark et al, 2013).

Carole Ivey strived to communicate the vital role she could play as an occupational therapist within the general education population. She discovered that school psychologists in the school system were in charge of "…defining the process of RtI within the district and independently identifying other professionals' roles, including occupational therapy, at each Tier" (Clark et al, 2013). The Department of Education in Virginia stated that, "…because occupational therapy is a related service provider in special education, they would not be involved in the RtI implementation," misunderstanding occupational therapy's distinct role in the school setting (Clark et al, 2013). As previously discussed, environmental barriers have a direct effect on the perception of occupational therapy in others' view. General education teachers were said to be overseeing the profession's meaning because they did not have the knowledge of what occupational therapy meant and its impact on children's success in school.

For Laurette Olson, New York fully supports their occupational therapists role in RtI by requesting that occupational therapists play a large role in refining and remediating Kindergarten fine motor skills (in-hand manipulation, handwriting, functional grasps) as these skills present in many Kindergarten activities (Clark et al, 2013). A pilot study focused on the implementation of a program, Kindergarten Fine Motor Center (KFMC). Occupational therapists were to provide a universal screening tool to students beginning Kindergarten that ran parallel to Tier 1 of RtI. Those students identified as having difficulty with the KFMC program were reassessed midyear and at

the end of the academic year. KFMC works on three strands including (Clark et al, 2013):

1) Sensory discrimination or fine motor strength
2) Dexterity
3) Skill development in using classroom tools

These strands are used to guide intervention and redesign activities that support Kindergarten curricula. Data throughout allows for the occupational therapist and teacher to monitor the student's progress and provides a helpful tool when parent/teacher conferences arrive. The occupational therapists can accompany the teacher to the meetings with the parents in order to convey how well collaboration has worked between the professionals in providing the best care possible to their child. Occupational therapists within this state are able to "…model strategies for teaching children fine motor skills, assist teachers in adapting curricular activities, supporting teachers in monitoring student progress, developing workshops for parents, and attend meetings" (Clark et al, 2013, p.3). The significance of this personal story came from the realization that occupational therapy must step back from a "disability model" and embrace the Tiers provided by RtI. However, it is important to note that occupational therapists are not responsible for academic instruction; that is the role of the general education teacher. Identifying and remediating the learning disabilities of children so that they can succeed in their classes' best represents the educational model through an occupational therapy lens.

Gloria Clark's personal story took place in the state of Iowa where occupational therapy is considered a support service rather than a related service (Clark et al, 2013).

The significance of this is that occupational therapy is the only service needing to be provided on a student's IEP instead of having to come in under another service such as speech therapy or psychology. This problem-solving method of service offered recommendations to general education and special education teachers to decrease the amount of inappropriate referrals for occupational therapy evaluations. However, with the more intensive forthcoming of a systems approach in the early 2000's, general education teachers held more emphasis on providing Tier 1-3 interventions. When referred to special education, an occupational therapist would provide short-term intervention methods to rate a student's response to intervention, their functional (not cognitive) discrepancy from peers, and educational needs (Clark et al, 2013). In 2009, state laws accommodated the use of occupational therapy services in the general education curriculum to provide short-term interventions to at-risk students prior to a special education evaluation.

Different from personal story perspectives is a pilot study that was conducted through the use of a survey to 12 occupational therapists in order to gain a better understanding of the recommendations made by occupational therapists, beyond that of handwriting, in the RtI process (Cahill, 2010). The following recommendations were provided by the participants during the data collection process: self-regulation (ability to either excite or calm the body in response to environmental stimuli, attending to task, fine motor (in-hand manipulation), gross motor (whole-body), handwriting (formation, spacing of letters, reversals, etc.), transitioning from one task or environment to another, self-help (bathing, toileting, feeding, dressing, etc.), and sensory processing (ability to identify, modulate, and discriminate incoming sensory information to be successful

within the environment) (Cahill, 2010). A surprising result of the study included the fact that occupational therapists did not comment on the use of scissor skills, short or long term memory, problem-solving skills, or organizational skills during the data collection process (Cahill, 2010). The findings conclude that the occupational therapist participants used more of their personal clinical reasoning skills as opposed to scientific-evidence which may have accounted for the items not mentioned within the data collection process, shown to be common struggles for students.

A third resource provided a case report of occupational therapists and physical therapists in an elementary school system describing their role responsibility and constantly changing workloads in an RtI approach (Reeder, Arnold, Jeffries, & McEwen, 2011). The findings of this study proved effective in demonstrating the therapists' perceived experiences screening and identifying students at-risk for developmental delays in fine and gross motor skills. By screening all students, occupational therapists and physical therapists accepted the possibility that every student could present with a developmental delay. Because occupational therapists and physical therapists worked closely with teachers to provide scientific-based interventions parallel to RtI and conducive to prewriting and writing, posture, bilateral integration of both upper and lower extremities, and sensory modulation, teachers began to better understand the significant impact both therapists could offer the classroom environment. However, with this recognition came more responsibility and therefore had a direct impact on workload expectations. To repress the amount of workload cases the therapists gained, they devised a flowchart that illustrated their individual scopes of practice, intervention ideas pertaining to their field, and offering ideas on how to locate resources (Reeder et al,

2011). During this study, there was an unfortunate shortage of two full-time occupational therapists resulting in a higher caseload and workload for the remaining occupational therapists. Discussed is the problem with little time acknowledged for all of the consultation between therapists and paraprofessionals taking place. The shortage of occupational therapists also resulted in the dislike of RtI implementation because of the expectations of assisting every student presenting with difficulties in learning.

A national survey conveying occupational therapists perceived level of preparedness for and involvement in school-based RtI found that occupational therapists would benefit from specific district guidelines outlining their specified role in RtI (Cahill, McGuire, Krumdick, & Lee, 2014). No evidence was found that identified occupational therapists perspectives related to working in RtI initiatives however, these perspectives are critical in determining the effectiveness of RtI implementation activities. Specifically, this study discusses four areas:

1) Current involvement of occupational therapy practitioners in RtI
2) Beliefs of practitioners in relation to their participation
3) Perceived barriers to practitioner's involvement
4) Factors perceived as facilitating practitioners involvement in RtI – (Cahill et al, 2014).

Out of 1,000 recruited practitioners, 295 responded. Percentages developed from the results of this study provide an effective visual aid. Results concerning participation in RtI concluded with 77.5% implementing RtI within their districts, 10.1% indicating that their districts were not considering implementing RtI, and 11.9% reporting that their districts were in the planning stages of RtI. Many respondents (69.2%) believed that RtI

is beneficial to occupational therapy whereas 60.1% identified a common barrier; school personnel are unfamiliar with occupational therapists role in RtI. Approximately half of the respondents (52.9%) believed that their fellow educators desired occupational therapists' participation in RtI and 52.5% of respondents demonstrated the desire to become more involved in the RtI process whereas 46.7% identified their skills as an occupational therapist not significantly used in RtI. These findings indicate a diverse representation of the perspectives occupational therapists experience in the school system in varying districts.

More than two-thirds of the participants (66.3%) supporting RtI in their districts described a large limitation to the implementation of RtI secondary to the lack of resources, time, personnel, administrative support, specific policies regarding practitioner involvement, and lack of knowledge on the part of practitioners. These limitations could quickly become facilitators. For example, guidelines depicting an occupational therapist's expectations throughout each Tier would greatly impact their participation in RtI. By treating fewer students with special needs on their caseloads and decreased responsibilities would also increase an occupational therapist's participation in RtI. Continuing education on the topic of providing services in RtI; direction on how to transfer more from a caseload to a workload perspective; and greater understanding on how to interpret national policy were all found to have an impact on increased involvement in RtI.

Ethical Dilemmas

Occupational therapists within the school system encounter ethical dilemmas on a daily basis that involve honesty, communication, ensuring the common good/doing no

harm, competence, confidentiality, conflict of interest, payment for services and other financial arrangements, and resolving ethical issues (Reitz, Austin, Brandt, DeBrakeleer, Franck, Homenko, McQuade, & Slater, 2005). These authors developed the guidelines to the occupational therapy code of ethics that best explain given circumstances potentially faced and which principle with the code of ethics is being breached.

Occupational therapists must then feel competent in their ability to provide specific services. Code of Ethics supports the variability of documentation as applicable to the laws, guidelines, and regulations within that particular district. A significant duty of occupational therapists is to ensure that employers are aware of the ethical principles within occupational therapy and practitioner's obligation to adhere to those ethical principles. It is described that occupational therapists should actively participate in procedural justice by taking the leadership role of formulating policies and procedures (such as RtI) in a legal way that is in accordance with regulations governing aspects of practice. Occupational therapy must ensure that skilled occupational therapy interventions are performed by qualified personnel and are responsible for ensuring the competence of those paraprofessionals they do train.

Methods

Qualitative Research Design

The purpose of this research study is to better define occupational therapists' perceived experiences implementing Response to Intervention (RtI) in early education. An initial phenomenological epistemological approach was used in order to gain insight on the different therapists lived experiences related to RtI. Each perspective develops the essence of the phenomenon experienced by all (Creswell, 2014). Each participant's

experience varied in many ways thus providing the study with rich significance. Because of the phenomenological epistemological foundation for the study, participant's verbal identification of their encounter with RtI became evidence not depicted by quantitative data. To better reflect and reason between the participants' expressions, a cross-case analysis was formed. A cross-case analysis of the data replaced a phenomenological analysis in order to highlight meaningful similarities and differences across the different perspectives. Without identification of the similarities and differences among participants, the significance of the results found would not be as meaningful to real-life practice.

Sampling

Participants were recruited by snowball sampling in which respondents provided information pertaining to other potential individuals eligible for the study that would be willing to participate (The Association for Qualitative Research, 2013). Potential participants were initially contacted by an email approved by the Institutional Review Board (IRB) for their voluntary participation and appreciation for participating in the study (Appendix A). If potential participants did not respond within two-weeks, a follow-up email was delivered, also approved by the IRB committee (Appendix B). Other forms of communication to accommodate participants for their time and energy included in-person semi-structured interviews, phone calls, and text messages not scripted.

This study's inclusion criteria included being a licensed occupational therapist with any experience implementing RtI in the school system. Although the sample size of

this study is extremely small, it should not discourage the amount of significance these experiences provide current literature and future research opportunities.

Participants

Participants were three full-time licensed occupational therapists working in counties from western, central, and eastern portions of Kentucky. All participants were English-speaking and cognitively sound. As displayed in Figure 1 (Appendix C), participants differed in the intensity of RtI implementation measured as minimum, moderate, and maximum levels. Participants traveled within their district to differing schools and these numbers differ amongst all participants. Caseload and Workload amounts of participants differed greatly as well as reimbursement methods for services.

Materials and Procedure

The proposed study was approved by the Institutional Review Board (IRB) of the Eastern Kentucky University Graduate School prior to beginning data collection in June of 2014. Each participant was provided a physical and verbal representation of the consent form for future reference as well as both a physical and verbal representation of the approval form provided by the IRB to prove legitimacy of the study (Appendix D & E). Each participant extensively read and signed the provided consent form indicating that this research study was completely voluntary and that they could decide to withdraw participation at any time without consequences. The principle investigator also conveyed that participants would not experience any harm and that there would not be incentives for their participation. At the beginning of each semi-structured interview, each participant reiterated that they read, agreed to, and signed the consent form. At the time of providing informed consent, the principle investigator described the purpose,

confidentiality, and voluntary nature of participation of the study. The participants read the informed consent and if they agreed, the study progressed. Participants were repeatedly informed regarding the confidentiality and voluntary participation components of the study so that mutual understanding and communication were fostered. Participants were offered structured and unstructured opportunities to ask any questions they desired pertaining to the study and its implications.

Each interview consisted of pre-established questions including the main broad general question, possible follow-up questions, and demographic questions (Appendix F). Probing questions were developed individually to further clarify points provided by each participant followed by further clarification when information presented was unclear to the principle investigator. The range in duration of the semi-structured interviews ranged from approximately 40 minutes to 90 minutes. The principle investigator utilized a digital recorder to capture the interviews. The digital interviews were transcribed verbatim. Participants were notified by the principle investigator inquiring about insufficient identification of words through transcriptions to improve the accuracy and overall flow of conversation.

Data Analysis

Data were analyzed using primary coding involving the principle investigator identifying triggers within the data indicating a need for deeper reflection (Miles, Huberman & Saldana, 2014). Triggers are understood to be specific words or phrases that elicited a meaningful concept that were significant to the purpose of the study. These triggers better highlighted the significance of the participants conveyed expressions and prompted the principle investigator to carefully read and reflect the meaning of each

word within each sentence. In-vivo coding best represents the primary stage of coding as it supports a beginner principle investigator's ability to honor the participants' voices (Miles et al, 2014). Secondary coding was reviewed by the thesis chair that resulted in increased trustworthiness of the study.

Once each participant's transcribed interviews were coded for meaning, relationships among each participant became identified as having the most emphasis on their ability to deliver services. These relationships developed into identified themes. Member checking was included in the data analysis process as evidenced by the principle investigator emailing each participant inquiring about their perceived level of emphasis in regards to the emerging themes. Each participant reviewed the principle investigator's initial thoughts regarding their perceived level of emphasis and made corrections where necessary. Uniform consensus was reached between the principle investigator and participants after the triangulation period reached saturation. Saturation of a study is the point in which all information has reached common agreement pertaining to varying views on a particular topic.

Chapter 2

Journal Manuscript

Abstract

Response to Intervention (RtI) in early education is viewed as a proactive response to remediating and refining students' learning disabilities to prevent unnecessary placement in special education. Occupational therapists' (OT) role in schools regarding RtI varies state-by-state, district-by-district. In order to understand occupational therapists perceived experiences implementing RtI in early education, a phenomenological epistemological study was produced. Findings suggest that states and districts have unprecedented interpretations of the law directly affecting the ability for OT's to provide services to students under RtI principles. Development of practice guidelines by the OT, continued education, and advocacy are needed.

Introduction

Some knowledge of early laws enacted to support children with learning disabilities helps to clarify the laws affecting Response to Intervention (RtI) implementation. The following laws and regulations are provided in chronological order to signify change and growth witnessed throughout history.

The Education for All Handicapped Children Act, also known as the constitutional protection for children with disabilities and their families, was passed in 1975 to ensure that "all handicapped children have available to them special education and related services designed to meet their unique needs" (Education for All Handicapped Children H.R. 7217, 1975; (Project IDEAL, 2013). It encompasses: 1) a Free, Appropriate, Public Education (FAPE) for all students; 2) a Least Restrictive

Environment (LRE); 3) an Individualized Education Program (IEP); 4) procedural due process; 5) nondiscriminatory assessment; and 6) parental participation (Project IDEAL, 2013). The FAPE component provides all students, regardless of the severity of the disability, an "education appropriate to their unique needs at no cost to the parent(s)/guardian(s)" and also includes the use of related services determined to be educationally relevant and beneficial to the student (Project IDEAL, 2013). The purpose of the LRE component is to provide students with disabilities the opportunity to receive the same education to the maximum extent possible as students without disabilities (Project IDEAL, 2013). An IEP is an individually tailored statement describing the educational route a child will travel with regards to special education and related services needed by the student. Procedural due process enables parent(s)/guardian(s) to have the right to confidentiality of records, the ability to obtain an independent evaluation, and to receive written notification of changes made to the student's educational track (Project IDEAL, 2013). Nondiscriminatory assessment implementation requires that students be evaluated by a multidisciplinary team in all areas of suspected disability and that this assessment not be biased on race, culture, and linguistics. Parental meaningful involvement helps ensure educational success of students.

In 1990, the Education for All Handicapped Children Act was replaced by the Individuals with Disabilities Education Act (IDEA) deleting the term "handicap" and replacing it with the term "disabilities" allowing for more attention to be on the individual rather than fixated on the labeled condition (Jackson, 2007). The IDEA provides financial support for state and local school districts for students aged 3-21 years of age as long as they comply with six main points:

1) Achieved FAPE

2) A school professional's belief that a particular student may have a disability impacting the student's ability to learn

3) Creation of IEP

4) Achieved LRE

5) Input received from both student and parent(s)/guardian(s) and

6) Confirmation that due process has taken place (American Psychological Association, 2014).

Although IDEA-04 contributes financially to special and regular education students, it is not significant and other forms of funds must be supplied.

No Child Left Behind Act of 2001 (NCLB) is the current version of the Elementary and Secondary Education Act of 1965 (No Child Left Behind Act of 2001 H.R. 1, 2001). NCLB is important in that it ensures that students with learning disabilities reach high levels of academic standards just like their peers who are not living with a disability. It is based on four core principles (National Center for Learning Disabilities, 2014):

1) Stronger accountability for results

2) Increased flexibility and local control (funding)

3) Expanded options for parents (availability of report cards and possible transfers to more accredited schools as applicable)

4) An emphasis on teaching qualifications and methods whereby all teachers must hold a bachelor's degree and have passed a state test of subject knowledge.

Schools are held accountable for what the students learn, how they learn it, and whether the methods chosen to teach material are successful. NCLB's accountability requirements for schools promote the inclusion of students with disabilities in the assessment experience as a result of receiving more general education exposure. NCLB also explains the need for accommodations uniquely designed for each student to help students demonstrate their knowledge and skills rather than the effects of their disability.

IDEA's most recent revision took place in 2004. With the revision, came its alignment with NCLB of 2001 to ensure that a quality program is provided for all children with special needs (Individuals with Disabilities Education Improvement Act of 2004 H.R.1350, 2004). The newest provision in this revision is the ability for schools to use a scientific, research-based intervention such as RtI as part of the evaluation process instead of using a discrepancy (IQ score) formula to identify students with learning disabilities (Project IDEAL, 2014). Although RtI is not mandated under IDEA or NCLB, the reauthorization of IDEA-04 uses language parallel to that of RtI. With IDEA, more children will have an array of services readily available to them including occupational therapy, often critical to the child's development and success in a LRE which will be examined more in-depth later in the article. The reader will learn how the mind and body are two separate entities. RtI is used not only in middle and high schools, but also in the elementary setting to aid children in reading, mathematics, and behavior (National Center on Response to Intervention, 2012)

Related services, such as occupational therapy, are seen as expensive health expenditures as opposed to an educationally relevant service within the school system. Medicaid is a federal-state matching entitlement program designed to help provide and

pay for health and medical services for low-income people. It is widely used in the school system (Jackson, 2007). Medicaid provides both a medical and educational lens to care. Each state is demanded to provide services to certain mandatory populations but have flexibility in determining coverage for optional population groups (Medicaid.gov, 2014).

ECE (Early Child Education) Program is devoted to meeting the needs of children who learn differently from their peers. This type of reimbursement system provides a small percentage of federal funding for occupational therapy services directly related to special education.

SEEK funding was started in 1990 in order to assist in equalizing funding for schoolchildren regardless of economic circumstances or place of birth and create a mechanism for distributing state support to local school districts (Kentucky Department of Education, n.d.). The costs associated with educating children with special needs and different disabilities is based on the number of students, student-teacher ratio for each disability or service, and a resulting per pupil cost (Kentucky Department of Education, n.d.).

Section 504 of the Rehabilitation Act of 1973 and Title II of the American with Disabilities Act (ADA) of 1990 constitute two civil rights statutes that prohibit discrimination on the basis of disability by programs receiving federal funds (section 504) and by services and activities of state and local governments (Reeder et al, 2011). Students who are not eligible for special education but have a disability that interferes with one or more aspects of life can receive occupational therapy services under this type of funding.

RtI gained recognition in 2001, was later (in 2002) endorsed by the President's Commission on Excellence in Special Education, and in 2003 was endorsed by other professional organizations (Christ, Burns, & Ysseldyke, 2005). RtI methods continue to evolve as the approach matures. The purpose of RtI is to make sure that, "…every child in the school receives instruction that leads to success" and this approach is endorsed by many nationally known organizations including the United States Office of Special Education, IDEA Partnership, and National Association of State Directors of Special Education (The National Center on Response to Intervention, 2012, p.4; Danielson, 2007). As a high-quality service and tool used to identify students with Specific Learning Disabilities (SLD), provided that rigorous scientific-based research is embedded in the general education curriculum, RtI is shown to work well with students requiring extra assistance in the classroom (National Center on Response to Intervention, 2012, p. 20). RtI is seen as a safety net in that it supplies students with appropriate supports before the student has a chance to fail (The IRIS Center for Training Enhancements [B], 2006). Some students who simply employ a different learning style may be unnecessarily placed in special education. RtI encourages the matching of diverse learners with the appropriate differentiated instruction thereby meeting students' needs in general education without the need of special education. In other words, RtI allows us to adjust the teaching method for the child instead of trying to change the child to fit the teaching method.

RtI has three Tier levels, each with the potential to increase in intensity, frequency, and duration of services depending on the specific needs of the student. Tier 1 encompasses a whole-classroom approach to intervention in which every student benefits

from the same instruction. This level is exceptionally beneficial according to the Division for Early Childhood of the Council for Exceptional Children (DEC), National Association for the Education of Young Children (NAEYC), and National Head Start Association (NHSA) because not only is it using the prescribed instruction to assist students already identified as having a learning disability but also to assist students who were not known to experience difficulties but who soon identify their own struggles in learning (Pretti-Frontczak, Carta, Dropkin, Fox, Grisham-Brown, Edwards, & Sandall, 2013; Shaprio, n.d.; The IRIS Center for Training Enhancements [A], 2006) . Students demonstrating difficulty in mastering abilities in Tier 1 will be given supplemental teaching and support that are provided in Tier 2. If the Tier 2 escalation is deemed unsuccessful, the student will be moved to Tier 3 and assisted with highly individualized teaching practices and possible referral for special education. Throughout each Tier, progress monitoring of a student's growth is used to measure the success of the level of instruction provided. From those results, adjustments may be made to increase or decrease the amount of support provided.

Discussions surrounding the implementation of RtI often expose controversy pertaining to the consistent execution of its principles or to its fidelity, despite the supportive literature (Castillo & Batsche, 2012). There is currently a lack of consistent implementation of RtI in the United States. There is also controversy as to whether RtI should be viewed in some contexts as more of an eligibility determination factor than a tool to improve student outcomes (Castillo & Batsche, 2012).

Kentucky envisions a future in which, "…all students reach proficiency and graduate from high school ready for college and careers" (Bailey et al, 2014). Belcher et

al (April, 2012) assisted in amending a new section under chapter 158 under HB69 of Kentucky Legislature to "…require the Department of Education [district-wide] to make available technical assistance, training, and a web-based resource to assist all local school districts in the implementation of the system (RtI) and instructional tools based on scientifically based research..." as a means to assist students experiencing difficulties in math, reading, writing, or behavior (p.2). This particular amendment also emphasizes the importance of the Department of Education's encouragement of districts to utilize both federal and state funds as appropriate to most effectively implement district-wide RtI.

According to the American Occupational Therapy Association [AOTA], occupational therapists are highly qualified, licensed professionals who work with an array of populations and medical conditions (AOTA, 2008). In school systems, occupational therapists can help promote function and engagement of all children in school participation. Occupational therapists are required to have background knowledge of advanced anatomy, neurophysiology, sensory processing, development, and mental health fields. Occupational therapists are specialists in the determination of appropriate instructional strategies in the school setting. The 2004 revision of IDEA allows occupational therapists to play more of a direct role in Early Intervening Services (EIS), throughout each Tier, for students in general education who do not receive special education services.

Occupational therapists possess the skills necessary to create an optimal environment through activity analyses (break down of body requirements per step in tasks) for student success, environmental modifications (including universal design where everyone benefits from the same service), and integration of assistive technology (devices

used to increase independence). Within the school-based setting, occupational therapists are qualified to provide direct and non-direct services including RtI that impacts the senses (Tactile, Oral, Vision, Auditory, and Olfactory) and motoric movement (Vestibular and Proprioceptive) of the child(ren). Occupational therapists are not only able to collect data on student progress throughout the Tiers but can offer the paraprofessional team information regarding determinants on the efficacy of intervention towards student outcomes. Occupational therapists devise adaptations as applicable to the needs of individual students and may offer supportive advice to the team including recommendations for students to receive more intensive or less intensive intervention. Occupational therapists facilitate student access to curriculum and extracurricular activities as well as play a critical role in training parents, caregivers, and other support staff on the diverse learning needs of students and how to best accommodate those skills and abilities (AOTA, 2010). Occupational therapists encounter ethical dilemmas on a daily basis that involve honesty, communication, ensuring the common good/doing no harm, competence, confidentiality, conflict of interest, payment for services and other financial arrangements, and resolving ethical issues (Reitz, Austin, Brandt, DeBrakeleer, Franck, Homenko, McQuade, & Slater, 2005).

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that occupational therapy, no matter the state's level of RtI adoption should advocate for their contributions to students educational successes (Clark et al, 2013).

Carole Ivey, representing Virginia, strived to communicate the vital role she could play as an occupational therapist within the general education population. The Department of Education in Virginia stated that, "…because occupational therapy is a related service provider in special education, they would not be involved in the RtI implementation," misunderstanding occupational therapy's distinct role in the school setting (Clark et al, 2013). General education teachers were said to be overseeing the profession's meaning because they did not have the knowledge of what occupational therapy meant and its impact on children.

For Laurette Olson, New York fully supports their occupational therapists role in RtI by requesting that occupational therapists play a large role in refining and remediating Kindergarten fine motor skills (in-hand manipulation, handwriting, functional grasps) as these skills present in many Kindergarten activities (Clark et al, 2013). The significance of this personal story came from the realization that occupational therapy must step back from a "disability model" and embrace the Tiers provided by RtI. This much involvement with RtI was said to have had an impact on the occupational therapists workload, or students seen outside of the general education classroom. Identifying the learning disabilities of children so that they can succeed in their classes', best represents the educational model through an occupational therapy lens.

Gloria Clark's personal story took place in the state of Iowa where occupational therapy is considered a support service rather than a related service (Clark et al, 2013). The significance of this is that occupational therapy can be the only service needing to be

provided on a student's IEP instead of having to come in under another service such as speech therapy or psychology.

RtI is becoming a more popular resource for intervention in early education, utilizing occupational therapists' clinical expertise and ability to refer to evidence-based practice. Occupational therapists unique role within the school system plays a significant part in proper development of children and increased independence in functional performance within meaningful occupations. Schools not utilizing occupational therapists in implementation of RtI are providing a disservice to their students. Although Clark et al (2013) provide three valuable personal stories pertaining to RtI in different states through an expert lens, little research has been identified in examining occupational therapists' lived experiences related to the implementation of RtI in early education. Therefore, the purpose of this research study is to better understand the lived experiences of occupational therapists who implement RtI principles in early education in the state of Kentucky.

Methods

Qualitative Research Design

The purpose of this research study is to better define occupational therapists' perceived experiences implementing Response to Intervention (RtI) in early education. An initial phenomenological epistemological approach was used in order to gain insight on the different therapists lived experiences related to RtI. Each perspective develops the essence of the phenomenon experienced by all (Creswell, 2014). Each participant's experience varied in many ways thus providing the study with rich significance. Because of the phenomenological epistemological foundation for the study, participant's verbal

identification of their encounter with RtI became evidence not depicted by quantitative data. To better reflect and reason between the participants' expressions, a cross-case analysis was formed. A cross-case analysis of the data replaced a phenomenological analysis in order to highlight meaningful similarities and differences across the different perspectives. Without identification of the similarities and differences among participants, the significance of the results found would not be as meaningful to real-life practice.

Sampling

Participants were recruited by snowball sampling in which respondents provided information pertaining to other potential individuals eligible for the study that would be willing to participate (The Association for Qualitative Research, 2013). Potential participants were initially contacted by an email approved by the Institutional Review Board (IRB) for their voluntary participation and appreciation for participating in the study (Appendix A). If potential participants did not respond within two-weeks, a follow-up email was delivered, also approved by the IRB committee (Appendix B). Other forms of communication to accommodate participants for their time and energy included in-person semi-structured interviews, phone calls, and text messages not scripted.

This study's inclusion criteria included being a licensed occupational therapist with any experience implementing RtI in the school system. Although the sample size of this study is extremely small, it should not discourage the amount of significance these experiences provide current literature and future research opportunities.

At the time of providing informed consent, the principle investigator described the purpose, confidentiality, and voluntary nature of participation of the study. The participants read the informed consent and if they agreed, the study progressed. Participants were repeatedly informed regarding the confidentiality and voluntary participation components of the study so that mutual understanding and communication were fostered. Participants were offered structured and unstructured opportunities to ask any questions they desired pertaining to the study and its implications.

Participants

(Figure 1 about here)

All participants were licensed occupational therapists who were English-speaking and cognitively sound. As displayed in Figure 1, participants differed in the intensity of RtI implementation measured as minimum, moderate, and maximum. The figure looks left to right in describing the emphasis the different identified themes (to be discussed later) had on the participants' descriptions and are chronologically labeled from most to least emphasis. Participants traveled within their district to differing schools and these numbers differ amongst all participants. Caseload and Workload amounts of participants differed greatly as well as reimbursement methods for services.

Materials and Procedure

The proposed study was approved by the Institutional Review Board (IRB) of the Eastern Kentucky University Graduate School prior to beginning data collection in June of 2014. Each participant was provided a physical and verbal representation of the consent form for future reference as well as both a physical and verbal representation of the approval form provided by the IRB to prove legitimacy of the study (Appendix D &

E). Each participant extensively read and signed the provided consent form indicating that this research study was completely voluntary and that they could decide to withdraw participation at any time without consequences. The principle investigator also conveyed that participants would not experience any harm and that there would not be incentives for their participation. At the beginning of each semi-structured interview, each participate reiterated that they read, agreed to, and signed the consent form.

Each interview consisted of pre-established questions including the main broad general question, possible follow questions, and demographic questions (Appendix F). Probing questions were developed individually to further clarify points provided by each participant followed by further clarification when information presented was unclear to the principle investigator. The range in duration of the semi-structured interviews ranged from approximately 40 minutes to 90 minutes. The principle investigator utilized a digital recorder to capture the interviews. The digital interviews were transcribed verbatim. Participants were notified by the principle investigator inquiring about insufficient identification of words through transcriptions to improve the accuracy and overall flow of conversation.

Data Analysis

Data were analyzed using primary coding involving the principle investigator identifying triggers within the data indicating a need for deeper reflection (Miles, Huberman, & Saldana, 2014). Triggers are understood to be specific words or phrases that elicited a meaningful concept that were significant to the purpose of the study. These triggers better highlighted the significance of the participants conveyed expressions and prompted the principle investigator to carefully read and reflect the meaning of each

word within each sentence. In-vivo coding best represents the primary stage of coding as it supports a beginner principle investigator's ability to honor the participants' voices (Miles et al, 2014). Secondary coding was reviewed by the thesis chair that resulted in increased trustworthiness of the study.

Once each participant's transcribed interviews were coded for meaning, relationships among each participant became identified as having the most emphasis on their ability to deliver services. These relationships developed into identified themes. Member checking was included in the data analysis process as evidenced by the principle investigator emailing each participant inquiring about their perceived level of emphasis in regards to the emerging themes. Each participant reviewed the principle investigator's initial thoughts regarding their perceived level of emphasis and made corrections where necessary. Uniform consensus was reached between the principle investigator and participants after the triangulation period reached saturation. Saturation of a study is the point in which all information has reached common agreement pertaining to varying views on a particular topic.

Results

Findings from Qualitative Analysis

Response to Intervention (RtI) is an emerging practice area in occupational therapy and is being demonstrated differently throughout western, central, and eastern Kentucky. The participants perceived experiences implementing RtI supplied extensive qualitative data necessary to expand upon professional interpretations of county laws and regulations as it pertains to their service delivery guidelines. Four major themes that describe important influences on how RtI is viewed by occupational therapists emerged:

1) The occupational therapists' individual meaning of RtI; 2) The different levels of Tiers encompassing special compared with regular education circumstances; 3) Reimbursement methods and how different types of billing systems directed the occupational therapists plan of care; and 4) The occupational therapists perceived role in implementing RtI within their district.

RtI Meaning

Participants agreed with Kentucky's stance on the inability for states, districts, and schools to fully implement IDEA. Lola identifies Kentucky's problem as being related to "…over-identifying children, so…we're going in with the most intensive supports and maybe that wasn't necessarily what the child needed." Even though this therapist's use of RtI is not as significant as the therapist who implements RtI extensively, she still demonstrates the need for RtI in the school setting. However, for that particular district, obtaining more occupational therapists positions to alleviate some of the pressure is not a valid option at this point in time.

Elle states that RtI has a viable role in assisting in a proactive response. "…instead of waiting until the child fails and then picking up the pieces." Because of IDEA, it may take up to 60 days for a referral to special education to go into effect. This participant also explains that 60 days is almost half the school year where children are not receiving services; "…RtI comes into play because we start to realize that we're waiting 60 days for everybody, maybe speech, OT, the psychologist, the teacher, the family." to gather all the testing material and that is time without intervention that the child is losing. RtI has provided a way for occupational therapists to be inserted back in the picture of early intervening services. This same participant states, "…and that's the great thing

about RtI…sometimes kids that are struggling a little that aren't on anyone's radar are getting interventions that are helping them" and "…with a little nudge, could be right where everyone else is."

Jan understood the question to be a little different. They used RtI meaning to define placement of students in the different levels of Tiers by stating,

> …every child in the school will have a card and it has their test scores for math and reading so you sit through with their last year's teachers and their current year teachers and they put them on a board to determine whether, based on their scores if they're Tier one, Tier two, or Tier three.

Tiers Encompassing Special vs. Regular Education

Each participant similarly described the three levels of RtI in a general way. Elle describes RtI's Tiers by stating:

> Tier 1 is comprised of teaching things like grip lessons; teaching right-left handedness; teaching positioning for writing; and how to sit in your chair for handwriting. Tier 2 would be where we provide equipment and we show the teacher how to use the equipment whether it's a slant board, wedge cushion, weighted glove, or weighted pencil. Tier 3 involves us screening or moving into an evaluation.

Jan discusses how students in the third, most intensive Tier, may still receive intervention strategies provided by level two encompassing both the support from an IEP and continued support from the general education teacher. Lola describes the outcome if the RtI levels were to be proven ineffective for a student struggling with learning by stating,

"…of course if a child ends up with an IEP, that means the modifications or the strategies that were used through RTI didn't work."

Reimbursement

IDEA-04 offers 15% of funds to be delegated to early intervening services where 85% is used for students in special education. Supplement forms of reimbursement were identified as including Medicaid, ECE funds, and SEEK funds. Each form of reimbursement ensues a particular desired way for related services such as occupational therapy to perform the delivery of service. Jan best exemplifies this controversy over the way in which various billing systems expect service delivery to occur by stating, "If I'm paid through special education funding then they don't want me to work with regular education kids, because then I'm kinda taking from one bucket and putting it back into regular education funds." Lola, whose school district decided to no longer accept Medicaid funding described the important Medicaid funding had on the integrity of service provision by stating:

> And our director is very concerned with the fact, as am I, that with Medicaid, you justify that a child's needs are medically necessary. And in the school system, we're looking at something totally different. We're looking for the educational relevance of the intervention that you're providing. Um, so our director has elected not to bill Medicaid so that's made our documentation a little different in the last couple of years.

Elle does not bill for services provided to RtI students because they are not on her caseload. However, notes representing contact service of students in RtI, teachers, and

other paraprofessionals are kept in a "soft cart" that will follow each student in RtI to the next grade.

Occupational Therapists Role in RtI

Because there was such variability in the perceptions of each participant's role as occupational therapists in RtI, it was deemed necessary to separate and closely evaluate each therapist's unique role in their district.

Elle (Maximum RtI Involvement)

Elle describes her experience as an occupational therapist as one that is universal. She works with both general and special education students, parents, teachers, school staff and paraprofessionals to ensure IDEA-04's vision for a Free and Appropriate Public Education (FAPE) within the Least Restrictive Environment (LRE). However, she describes occupational therapy as not always being a valuable service provided under RtI because of the academics portion by stating, "…as an Occupational Therapist, we just felt like we weren't really a part of that process…as RtI moved on in academia; OT was kind of left out." Elle goes on to demonstrate the need for her to constantly advocate for occupational therapy as advocacy plays a large role in the growth and sustainability of a profession. Elle describes her role in RtI as vital by stating, "…without OT, it's going to be very difficult for them [students] to meet their RtI goals readdressing some of the underlying components, and the skills and concerns with writing goals." Elle describes a very important skill of occupational therapists that other professionals do not possess including observations and describes this skill as "…one of the best things we have and we're good at it." Elle's involvement in RtI can best be summed up by the following statement:

> For RtI, you can't really directly pull those children but…if I have to go over and say, here's the pencil grip little Johnny and it's kind of hard to use so I am going to show you… I am just educating him on how to use it…because what's the point in giving it to him if he can't ever figure out where to put his fingers?

This quote demonstrates how important it is for an occupational therapist to reason through what may or may not be considered ethical. For instance, because this particular child, Johnny, is not on an IEP, the occupational therapist is limited in direct service implementation. However, she deemed it necessary to provide direct service so that "little Johnny" would learn how to effectively use the assistive technology to promote his learning. Elle is always moving about in the school providing assistance in the gym, at lunch, at recess, or even on the school busses.

Jan (Moderate RtI Involvement)

Jan describes her role as an occupational therapist as one who, "…works with a large variety of kids…who have different abilities and disabilities, so we provide lots of sensory support, lots of fine motor support, visual-motor strategies." Although Jan mainly works with students in Tier 3 of RtI, those students being evaluated for an IEP, she has discovered that,

> the easiest way to get them (teachers) to do what I want…for my IEP students who receive OT, is to help them out with those other kids (regular education) too…because that builds the rapport with the teacher.

Jan's role involves cooperation strategies to better work as a team for the student body. An ethical dilemma reached with Jan is that her work is not solely limited to special

education but instead, reaches out to the general education population. Jan has succumbed to increasing her workload for the sake of her caseload. Although Jan does not provide direct service implementation on students in RtI without parent permission, she does perform whole-class initiatives so that every student benefits. As an occupational therapist within this particular school district, she describes her inability to promote the use of outside occupational therapy services, as it would, "make it the county's responsibility, legally, to pay for it I think." Another ethical dilemma faced by Jan is portraying to parents the best appropriate plan of care for their child. If school-based occupational therapy is not proving to be effective, and the student would benefit from more intensive services that only outpatient pediatric occupational therapy services could provide, then a disservice is being brought upon the student at hand. The main difference between settings (school vs. outpatient) is the availability of equipment and goals set for therapy.

Lola (Minimum Involvement in RtI)

Lola's role in RtI is best defined by the following statement, "I just kind of spoke to my director…she is actually on a state level team for exceptional children…and she told me that really I don't have a role with RtI." As being the only occupational therapist in the district, she really doesn't have time to "…worry about that (RtI)." Lola does explain that if a child enters the school and they already are diagnosed with a medical condition such as Autism or Cerebral Palsy, the school district must still provide RtI implementation. The student's educational and academic needs are assumed to require that of special education. Lola then is able to, "work at the same time that the RTI team does, but my focus is evaluation. It's not implementing RTI." In order for Lola to provide services to

a student, "…they have to be an identified child or in the process of being identified. So RTI children fall out of that."

Lola works with a large population of special education students of varying severity. Lola describes her role in special education as that of, "…not necessarily what I am doing with the child…it's more my observations of how that child is responding and then I can change up their program based on what I see." Lola also states that, "…as long as I'm working with children that are identified, they really feel like they're getting their bang for their buck." An ethical dilemma that pertains to this situation involves the understanding of how students not in special education, needing services but are not eligible, receive necessary care. In terms of the entire district, Lola states, "I'm pretty free to help really anyone in the district um as I want to, but of course I'm not talking about the RTI process."

Discussion

The importance of states abiding by said federal laws and regulations make it possible for everyone to benefit from the same services. However, because districts hold the ability to interpret their understanding of the state law, a great deal of variability is apparent. The variability experienced produces success for some students and disservice to others.

RtI meaning was identified as a theme because each participant discussed RtI's significance within the school system even if their involvement with RtI was minimal. When participants were asked to describe RtI in their own words, there were similarities however, the passion behind the meanings correlated with the level of RtI implementation that particular participant experienced. Elle felt that they held a large amount of accountability to serving students with learning difficulties in general

education who were not eligible for special education services. Mutual feeling was expressed by Laurette Olson, the occupational therapist from New York (Clark et al, 2013).

Contrary to the views of Clark et al (2013) slightly were the participants who had moderate and least involvement in RtI. Jan sought providing assistance in RtI in the general education curriculum as a buffer for assistance from teachers with her students in special education. The vignette relating best to this therapist includes that of Ivey in Virginia because of the misconstrued understanding of impact occupational therapists have on students with and without disabilities (Clark et al, 2013). Whereas Ivey needed to advocate more for occupational therapy services, the participant from this study felt as though she had to bribe other professionals.

Lola could not possibly fathom the amount of work that would be required to sustain both implementation of RtI and effectively serving those students in special education, being the only occupational therapist in the district. Clark et al (2013), did not offer an experience matching this participant.

Tiers encompassing special and regular education initiatives were discovered by the participants. These findings correlated directly with the participants' role determined by the district. Each participant identified the different levels of Tiers in RtI the same while asked to define RtI, not specifying their roles as occupational therapists at first. Each therapist, in some shape or form described the Tiers as embedding the following principles. Tier 1 encompasses a whole-classroom approach to intervention in which every student benefits from the same instruction. Students demonstrating difficulty in mastering abilities in Tier 1 will be given supplemental teaching and support that are

provided in Tier 2. If the Tier 2 escalation is deemed unsuccessful, the student will be moved to Tier 3 and assisted with highly individualized teaching practices and possible referral for special education. When describing occupational therapy's contribution to each Tier, similarities and differences appeared. Dependent upon the amount of involvement with RtI depicted the participant's contributions to each Tier. As provided by occupational therapy's scope of practice, occupational therapists have the knowledge and skills required to create an optimal environment through activity analyses (break down of body requirements per step in tasks) for student success, environmental modifications (including universal design where everyone benefits from the same service), and integration of assistive technology (devices used to increase independence) provided any given Tier of RtI (AOTA, 2008). Participants felt as though occupational therapy should be a part of the RtI process but that extenuating circumstances sometimes makes implementing RtI a hassle coinciding with Clark et al's (2013) beliefs.

Reimbursement varied amongst the three participants and plays a large role in the implementation of RtI as it guides related services such as occupational therapy. Each participant works under different reimbursement systems reflecting their differences in implementation of RtI. Particular funds allocate money disbursements for services only for specific use. Participants found reimbursement to be both a barrier to supplying services to students in need as well as demanding different documentation accountability from the occupational therapists. For example, Elle does not bill for those services but instead maintains an RtI folder for the school to track the workload of the therapist. Both Elle and Jan complete online documentation under Medicaid reimbursement for their special education students. Lola completes narrative notes as these are not part of

Medicaid funding. This particular district exited out of Medicaid reimbursement and only is funded under SEEK funds. Documentation is kept for organizational purposes and possible audits.

The occupational therapy role within RtI varied between participants. Elle had more of a direct role with RtI and provided "activity folders" for Tier 2 RtI students offering extra practice in areas of concern including visual perception, visual motor, etc. that is implemented by the teacher but created by the occupational therapist. Elle relates to the vignette of Clark in New York who also had a direct role in RtI and also took the time and initiative to provide what would be considered one-on-one intervention with a student not on an IEP in order to properly show the student how to use a particular piece of equipment (Clark et al, 2013). Justification for the practicality of the student knowing how to use the equipment was provided so that it did not seem unethical to the participant's role in RtI. Jan has a role that assists regular education students (students not on her caseload) in order to receive cooperation from teachers with her students in special education. Lola offers websites to teachers to utilize and implement RtI principles (including sensory processing), and provides collaboration and consultation to build teacher skills on specific matters.

Ethical dilemmas emerged as particular instances were discussed including that of demonstrating how to use assistive equipment to a student not on an IEP, assisting a teacher with a workload case so that better results will be provided to their students in special education, and providing sensory integration techniques to teachers unfamiliar with the neuroscience and anatomy behind the theory. To keep within the confidential boundaries of this study, potentially breached code of ethics will be listed but not

matched to a particular participant. Under Beneficence (Do Good), two principles are thought to have been compromised, as evidenced by the data, including: "Provide OT education, continuing education, instruction, and training that are within the instructor's subject area of expertise and level of competence" and "Take responsibility for promoting and practicing OT on the basis of current knowledge and research and for further developing the profession's body of knowledge" (Reed, Hemphill, Ashe, Brandt, Estes, Foster, Homenko, Jackson, & Slater, 2010). These two principles denote the need for occupational therapists to consult within their realm of practice providing others with information suitable to that particular audience's skill base and knowledge. Occupational therapists must also take the responsibility in advocating for emerging practice areas such as that of RtI in order to develop and expand the profession's knowledge and understanding.

Nonmaleficence, (Do No Harm), states to "avoid comprising client rights or well-being based on arbitrary administrative directives by exercising professional judgment and critical analysis" (Reed et al, 2010). Occupational therapists have a role in the implementation of RtI and to not promote that role is a disservice to the students who are lacking RtI supports. Occupational therapists are left to inquire about the "right thing to do" in situations such as these because of other extraneous variables and sometimes without meaning to, are unable to attend to others in the process.

Social justice demonstrates the need to, "uphold the professions altruistic responsibilities to help ensure the common good" (Reed et al, 2010). The responsibility of occupational therapy in the school system is to the students. The common good would

be for everyone to benefit from RtI implementation so that failure is not an option for students having difficulty learning or obtaining their role as student.

Procedural Justice is the last of the code of ethics that pertained to this particular study and states, "Be familiar with and seek to understand and abide by institutional rules, and when those rules conflict with ethical practice, take steps to resolve the conflict" and "Actively participate with employers in the formulation of policies and procedures to ensure legal, regulatory, and ethical compliance" (Reed et al, 2010). Federal laws and regulations impact both state and local policies and guidelines. As occupational therapists with their own scope of practice that governs their ability to serve others, they must effectively communicate their needs when faced with ethical dilemmas such as that of law implementation. Occupational therapists are equipped to present information to the districts in regards to practice guidelines because they have a much better picture of their capabilities than those who do not obtain an occupational therapy license. Occupational therapists must be the agents of change they are known to be in order for RtI to be as effective as its potential.

Implications for Occupational Therapy Practice

As identified in this study, there is evidence to support the need for more consistency of district adoptions when it comes to preventative programs such as RtI. The occupational therapists' understand the lack of practice knowledge some paraprofessionals have about the services occupational therapy can provide students and therefore should provide continued education for those unfamiliar. Occupational therapists should advocate for services within their school and district. This includes developing their own form of RtI, especially if states decide not to implement RtI.

Waiting for the district to implement a program such as RtI may not be feasible or desired.

Chapter 3

Discussion

Students are protected under certain laws such as The Individuals with Disabilities Education Act of 2004 (IDEA-04) and No Child Left Behind Act of 2001 (NCLB-01). These laws govern and mandate the success of students in the school setting by providing related service opportunities to assist students in their learning. The importance of states abiding by said federal laws and regulations make it possible for everyone to benefit from the same services. However, because districts hold the ability to interpret their understanding of the state law, a great deal of variability is apparent. Reimbursement methods also put in perspective the type and amount of services provided and to which individuals' services are provided. This inconsistency increases the likelihood that some services are being implemented in some areas. Students in a school district not implementing any form of Tiered intervention such as RtI, are at a distinct disadvantage.

As a related service under IDEA-04, occupational therapists' role in the school setting is deemed universally relevant since it addresses both educational and medical components of student's learning. Occupational therapists obtain the ability to abide by the states core standards for learning, as this is how services are reimbursed. Occupational therapists fit well into the school setting by integrating their practical knowledge of theory and intervention with the functional abilities of students in the classroom. AOTA supports the role of occupational therapist in the implementation of RtI specifically by stating that, as a profession, occupational therapy provides the skills

and knowledge necessary to reach multiple audiences experiencing diverse and simple-to-complex conditions.

Kentucky reports the failure of complete law implementation due to the lack of understanding in how to teach students with different learning styles and this lack of understanding results in some students lagging behind their peers (Taylor, 2010). Kentucky identifies RtI as one of two methods used to identify those students with learning disabilities. RtI encourages the matching of diverse learners with the appropriate differentiated instruction thereby meeting students' needs in general education without the need of special education. In other words, RtI allows us to adjust the teaching method for the child instead of trying to change the child to fit the teaching method.

Little literature has been published in identifying occupational therapists perceived experiences implementing RtI. This phenomenological and cross-case analysis driven study assists in filling in this gap. This study revealed four emerging themes: 1) RtI meaning viewed by each participant; 2) Tiers encompassing special versus regular education; 3) Reimbursement methods and their impact on service delivery; and 4) Occupational therapists' role in implementing RtI and the plausible ethical dilemmas that developed.

RtI meaning viewed by each participant

The meaning of RtI was identified as a theme because each participant discussed RtI's significance within the school system even if their involvement with RtI was minimal. When participants were asked to describe RtI in their own words, there were similarities however, the passion behind the meanings correlated with the level of RtI

implementation that particular participant experienced. The participant with the most involvement in RtI felt that they held a large amount of accountability to serving students with learning difficulties in general education who were not eligible for special education services. The participant with moderate involvement sought providing assistance in RtI in the general education curriculum as a buffer for assistance from teachers with her students in special education. The participant with the least amount of involvement in RtI could not possibly fathom the amount of work that would be required to sustain both implementation of RtI and effectively serving those students in special education, being the only occupational therapist in the district.

Tiers encompassing special versus regular education

Tiers encompassing special and regular education initiatives were discovered by the participants. These findings correlated directly with the participants' role determined by the district. Each participant identified the different levels of Tiers in RtI the same while asked to define RtI, not specifying their roles as occupational therapists at first. Each therapist, in some shape or form described the Tiers as embedding the following principles. Tier 1 encompasses a whole-classroom approach to intervention in which every student benefits from the same instruction. Students demonstrating difficulty in mastering abilities in Tier 1 will be given supplemental teaching and support that are provided in Tier 2. If the Tier 2 escalation is deemed unsuccessful, the student will be moved to Tier 3 and assisted with highly individualized teaching practices and possible referral for special education. When describing occupational therapy's contribution to each Tier, similarities and differences appeared. Dependent upon the amount of involvement with RtI depicted the participant's contributions to each Tier. As provided

by occupational therapy's scope of practice, occupational therapists have the knowledge and skills required to create an optimal environment through activity analyses (break down of body requirements per step in tasks) for student success, environmental modifications (including universal design where everyone benefits from the same service), and integration of assistive technology (devices used to increase independence) provided any given Tier of RtI (AOTA, 2008). Participants felt as though occupational therapy should be a part of the RtI process but that extenuating circumstances sometimes makes implementing RtI a hassle.

Reimbursement methods and their impact on service delivery

Reimbursement varied amongst the three participants and plays a large role in the implementation of RtI as it guides related services such as occupational therapy. Each participant works under different reimbursement systems reflecting their differences in implementation of RtI. Particular funds allocate money disbursements for services only for specific use. Participants found reimbursement to be both a barrier to supplying services to students in need as well as demanding different documentation accountability from the occupational therapists. For example, Participant with the most involvement in RtI, does not bill for those services but instead maintains an RtI folder for the school to track the workload of the therapist. Both the participant with the most involvement and the participant with moderate involvement in RtI complete online documentation under Medicaid reimbursement for their special education students. The participant with the least involvement in RtI completes narrative notes as these are not part of Medicaid funding. This particular district exited out of Medicaid reimbursement and only is funded

under SEEK funds. Documentation is kept for organizational purposes and possible audits.

Occupational therapists' role in implementing RtI and the plausible ethical dilemmas that developed

The occupational therapy role within RtI varied between participants. The participant with the most involvement in RtI had more of a direct role with RtI and provided "activity folders" for Tier 2 RtI students offering extra practice in areas of concern including visual perception, visual motor, etc. that is implemented by the teacher but created by the occupational therapist. This participant also took the time and initiative to provide what would be considered one-on-one intervention, with a student not on an IEP, when showing the student how to use a particular piece of equipment. However, this participant justifies this assistance by stating that the student will not know how to properly use the equipment without instruction. The participant with moderate involvement in RtI has a role that assists regular education students (students not on her caseload) in order to receive cooperation from teachers with her students in special education. The participant with the least involvement in RtI offers websites to teachers to utilize and implement RtI principles (including sensory processing), and provides collaboration to build teacher skills on specific matters. Ethical dilemmas emerged as particular instances were discussed including that of demonstrating how to use assistive equipment to a student not on an IEP, assisting a teacher with a workload case so that better results will be provided their students in special education, and providing sensory integration techniques to teachers unfamiliar with the neuroscience and anatomy behind the theory.

These findings support the main literature of Clark, Ivey, and Olson's (2013) description of personal stories pf occupational therapists' working in RtI, because they too found implementation of RtI to be inconsistent in their particular state studied. Although these authors found that the general education teachers were unaware of the meaning of occupational therapy, this study identified that teachers do seek assistance from occupational therapists, however, may be hesitant of such act. As a result, occupational therapists increase their workload significantly corresponding to the findings discovered in the national survey recently published (Cahill et al, 2014). Clark et al (2013) also described a state in which occupational therapists played an extremely large role in each Tier of RtI, whereas participants in this study were labeled as having minimum, moderate, or maximum involvement in RtI. Each participant described occupational therapy as a related service, meaning that occupational therapy has to relate to another service in order to provide intervention. Clark et al (2013) described Clark's experience with occupational therapy being considered a support service rather than a related service meaning that occupational therapy did not have to relate to another profession in order to be placed on the student's IEP. Occupational therapists were then able to construct their own goals pertaining to education as opposed to fitting in the goals of other professions which can be harder to accomplish.

As identified in this study, there is evidence to support the need for more consistency of district adoptions when it comes to preventative programs such as RtI. The occupational therapists' understand the lack of practice knowledge some paraprofessionals have about the services occupational therapy can provide students and therefore should provide continued education for those unfamiliar. Occupational

therapists should advocate for services within their school and district. This includes developing their own form of RtI, especially if states decide not to implement RtI. Waiting for the district to implement a program such as RtI may not be feasible or desired.

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APPENDIX A

IRB Approved Email Script

To: (Receiver Email Address)

From (Sender Email Address)

Date: _____

Title: Thank you for your interest in volunteering!

Body:

Greetings! My name is McKenzie Katzman and I am a first year graduate student in Eastern Kentucky University's Masters of Occupational Therapy Program. The purpose of this research study is to gain a better perspective of the lived experiences of occupational therapists implementing Response to Intervention (RtI) in early education.

As part of the formal study, participants will be asked to complete an interview and possible subsequent interviews lasting approximately 30 minutes. Interview questions will be directed towards personal experiences regarding the topic that remain confidential at all times. Volunteering to participate in the study is completely optional. At any time you feel the need to withdraw from the study, no penalties will be given.

But before enrolling individuals into the study, certain criteria need to be met by participants for eligibility. These questions should not cause any uncomfortable distress but if so, please let me know. You also need to understand that all information I receive from you by phone, including your name and any other identifying information (if applicable), will be strictly confidential. Please remember also that your participation to volunteer is completely optional and is not being forced. The purpose of these questions is only to determine whether you are eligible for the research study.

Questions:

1) Have you experienced implementing RtI while working with students in the school setting? (Yes or No)
2) Are you a licensed and certified occupational therapist? (Yes or No)
3) Do you work full-time or part-time? (Choose one)
4) Do you have any questions for me? If so, please reply here.

Once I receive your response, you will be contacted within 24 hours of when to set up an initial meeting, if applicable, to begin the research study process. Please contact me with any concerns or questions at:

Principle Investigator: McKenzie D. Katzman, OTS

Phone Number: 859-619-5978
Email: mckenzie_katzman@mymail.eku.edu

Thank you for your time,

McKenzie D. Katzman, OTS
Occupational Therapy Student
Eastern Kentucky University
mckenzie_katzman@mymail.eku.edu

Appendix B

IRB Approved Follow-up Email Script

To: (Receiver Email Address)

From (Sender Email Address)

Date: _____

Title: Thank you for your interest in volunteering!

Body:

Greetings!

Thank you again for your interest in volunteering to participate in the research study entitled, “Occupational Therapists' Lived Experiences Implementing Response to Intervention (RtI) in Early Education.”

It seems as though we have not completed the preliminary steps of the research study. To complete your volunteer participation, please respond to this email within 48 hours to confirm your position.

If you have any questions about the research study, please do not hesitate to contact the following individuals regarding further information:

Principle Investigator:
McKenzie D. Katzman, OTS
Phone Number: 859-619-5978
Email: mckenzie_katzman@mymail.eku.du

Faculty Advisor:
Dr. MaryEllen Thompson PhD, OTR/L
Phone Number: (859)-622-6347
Address: 521 Lancaster Avenue
Dizney 103
Richmond, KY 40475-3102
Email: MaryEllen.Thompson@eku.edu

Thank you and I look forward to hearing from you soon!

Sincerely,

McKenzie D. Katzman OTS, Principal Investigator

Dr. MaryEllen Thompson PhD OTR/L, Faculty Advisor

Appendix C

Figure “Participant Description”

OT Emphasis on Involvement Matrix

	Maximum Involvement (Elle)				Moderate Involvement (Jan)				Minimal Involvement (Lola)			
	Most	_	_	Least	Most	_	_	Least	Most	_	_	Least
OT role	Collaboration	Consultation	Meetings	Rx	Collaboration	Rx	Meetings (IEP)	Consultation	Meetings	Consultation	Collaboration	Rx
Reimbursement	IDEA B	Medicaid			Medicaid	ECE Funds			SEEK Funds			
Tiers / Special vs Regular *	Special Ed	3 (Assessment only)	2 (Center and Activity folders)	1 (Whole Class)	Special Ed	3 (Assessment only)	1 (Whole Class)		Special Ed	3 (Assessment only)		
RtI meaning	Very Positive					Positive					Neutral	
Case load / #Schools	68-IEP 15 –RtI & Workload /4					64-direct, 13- under COTA /5					65/ 11 different schools	

Response to Intervention Tiers:

* Tier 1 – Regular Ed students = total classroom intervention
* Tier 2 – Regular Ed students = more intensive accommodations/activities
* Tier 3 – Regular Ed transition to Special Ed
* Special Ed

Figure 1. Participant Description

Appendix D

IRB Approved Consent Form

Consent to Participate in a Research Study

OCCUPAITONAL THERAPISTS' LIVED EXPERIENCES IMPLEMENTING RESPONSE TO INTERVENTION (RtI) IN EARLY EDUCATION

Why am I being asked to participate in this research and what is the purpose of the study?
You are being invited to participate in this study because you are an occupational therapist using RtI. If you take part in this study, you will be one of about six people to do so. The following study is about capturing the unique lived experiences of occupational therapists implementing Response to Intervention (RtI) in Early Education. Although each occupational therapist has experienced the same particular phenomenon of interest, each will demonstrate a different perspective. This study will attempt to detail common aspects of occupational therapists' roles, responsibilities, failures, and successes as those relate to RtI.

Who is doing the study?

The person in charge of this study is McKenzie D. Katzman, OTS (PI) at Eastern Kentucky University. She is being guided in this research by MaryEllen Thompson, Ph.D., OTR/L. There may be other people on the research team assisting at different times during the study.

What will I be asked to do?

After being notified of your consent to participate, you will first sign this form. Next, we will complete an in-person interview for approximately 30 minutes regarding your experiences as an occupational therapist implementing RtI. The interview will recorded for transcription purposes. You will be asked to provide efficient communication (email, telephone –call/text, postal service mail, in-person, etc.) to the principle investigator and if needed, accommodations will be honored.

Where is the study going to take place and how long will it last?

The research procedures will be conducted at an agreed upon meeting place. You will need to come one time during the study. This meeting will take about 30 minutes.

What are the possible risks and discomforts?
To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

Will I benefit from taking part in this study?
You will not get any personal benefit from taking part in this study. However, the results of this study may benefit other occupational therapists using RtI.

Confidentiality:
Confidentiality of participants will be kept through the use of pseudonyms. Actual names matched with either pseudonym or letter and will be documented for principle investigator's own use and stored securely in locked cabinet of thesis advisor's office. The principal investigator and faculty advisor will be the ONLY individuals to access data during the research study. Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

Taking part is voluntary:
Participation is 100% **voluntary** and <u>without compensation</u>. For any reason you wish to withdraw your participation from the research study at any time, there will be no penalty. Any documentation you produce, after deciding to discontinue participation, will be properly destroyed. You will then be notified of such event. It is stressed that participants understand that volunteering is completely optional.

If you have questions:
Please do not hesitate to contact the principle investigator (researcher) or faculty advisor with any questions or concerns. Your participation is greatly appreciated and valued. Contact information is:

Principle Investigator: McKenzie D. Katzman, OTS at (859) 619-5978
Email: mckenzie_katzman@mymail.eku.du
Faculty Advisor: Dr. MaryEllen Thompson PhD, OTR/L at (859)-622-6347
Email: MaryEllen.Thompson@eku.edu

If you have any questions about your rights as a research volunteer, contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636. We will give you a copy of this consent form to take with you.

What else do I need to know?

You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

Statement of consent:

I have read the above information, and have received answers to any questions I asked. I have consented to take part in the study. The purpose and nature of the study has been explained to me in writing. I am participating voluntarily. I understand that the interview will be tape recorded. I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating. I understand that confidentiality will be ensured in the write-up by disguising my identity. I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

_____ _____

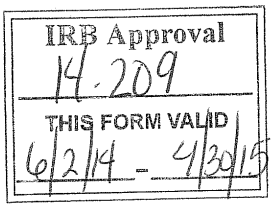
Signature of person agreeing to take part in the study Date

_____

Printed name of person taking part in the study

_____

Name of person providing information to subject



Appendix E

Approved IRB Form

Graduate Education and Research
Division of Sponsored Programs
Institutional Review Board

EASTERN KENTUCKY UNIVERSITY
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Jones 414, Coates CPO 20
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NOTICE OF IRB APPROVAL

Protocol Number: 14-209

Institutional Review Board IRB00002836, DHHS FWA00003332

Review Type: ☐Full ☒Expedited

Approval Type: ☒New ☐Extension of Time ☐Revision ☐Continuing Review

Principal Investigator: **McKenzie D. Katzman** Faculty Advisor: **Dr. MaryEllen Thompson**

Project Title: **Occupational Therapists' Lived Experiences Implementing Response to Intervention (RtI) in Early Education**

Approval Date: **06/02/2014** Expiration Date: **4/30/15**

Approved by: **Dr. Jim Gleason, IRB Member**

This document confirms that the Institutional Review Board (IRB) has approved the above referenced research project as outlined in the application submitted for IRB review with an immediate effective date.

Principal Investigator Responsibilities: It is the responsibility of the principal investigator to ensure that all investigators and staff associated with this study meet the training requirements for conducting research involving human subjects, follow the approved protocol, use only the approved forms, keep appropriate research records, and comply with applicable University policies and state and federal regulations.

Consent Forms: All subjects must receive a copy of the consent form as approved with the EKU IRB approval stamp. Copies of the signed consent forms must be kept on file unless a waiver has been granted by the IRB.

Adverse Events: Any adverse or unexpected events that occur in conjunction with this study must be reported to the IRB within ten calendar days of the occurrence.

Research Records: Accurate and detailed research records must be maintained for a minimum of three years following the completion of the research and are subject to audit.

Changes to Approved Research Protocol: If changes to the approved research protocol become necessary, a description of those changes must be submitted for IRB review and approval prior to implementation. Some changes may be approved by expedited review while others may require full IRB review. Changes include, but are not limited to, those involving study personnel, consent forms, subjects, and procedures.

Annual IRB Continuing Review: This approval is valid through the expiration date noted above and is subject to continuing IRB review on an annual basis for as long as the study is active. It is the responsibility of the principal investigator to submit the annual continuing review request and receive approval prior to the anniversary date of the approval. Continuing reviews may be used to continue a project for up to three years from the original approval date, after which time a new application must be filed for IRB review and approval.

Final Report: Within 30 days from the expiration of the project, a final report must be filed with the IRB. A copy of the research results or an abstract from a resulting publication or presentation must be attached. If copies of significant new findings are provided to the research subjects, a copy must be also be provided to the IRB with the final report.

Other Provisions of Approval, if applicable: None

Please contact Sponsored Programs at 859-622-3636 or send email to tiffany.hamblin@eku.edu or lisa.royalty@eku.edu with questions about this approval or reporting requirements.

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Appendix F

Interview Questions

Broad General Question

1. Tell me about your experiences using Response to Intervention

Possible Follow up Questions

1. What is your personal definition of Response to Intervention?
2. Describe your approach towards Response to Intervention as an OT.
3. Was there a time in which you were not using RtI? Explain.
4. Were you aware of the implementation of Response to Intervention within the school setting before applying for a position as an OT? If yes, describe your reaction.
5. Do you have any questions for me?